Dannel P. Malloy
Governor

State of Connecticut
Department of Developmental Services

DDS

Terrence W. Macy, Ph.D.
Commissioner

Joseph W. Drexler, Esq.
Deputy Commissioner

DEPARTMENT OF DEVELOPMENTAL SERVICES TESTIMONY BEFORE THE PUBLIC HEALTH COMMITTEE

H.B. No. 6388 - An Act Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities

February 27, 2013

Senator Gerratana, Representative Johnson, and members of the Public Health Committee. I am Terrence W. Macy, Ph.D., Commissioner of the Department of Developmental Services (DDS). Thank you for the opportunity to testify in support of our agency bills **House Bill 6388 - An Act Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities.**

House Bill 6388 originated when the final rule from the Centers for Medicare and Medicaid Services (CMS) was published changing the term "Intermediate Care Facility for the Mentally Retarded (ICF/MR)" to the more respectful and more "person first" term "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)". This change in federal terminology allowed DDS to move forward with its efforts to remove all references to the term "mental retardation" in Connecticut statutes. This bill changes all references from ICF/MR to ICF/IID to conform with CMS terminology.

Previous legislation (Public Act 11-4) eliminated almost all references to "mental retardation" in state statutes. However, it has come to our attention that various state agency statutes (DMV, DVA, DSS, DCF, etc.) still contain stray references to "the mentally retarded" or "mental retardation". We have contacted all agencies with these references in their statutes and have now received their approval to make the change to "intellectual disability" and "person first" language. As you may imagine, getting approval from 10 state agencies to change their statutes was time consuming. DDS did finally get all agencies to sign off but not before our bill was submitted to the Public Health Committee. We ask that you consider adding the attached proposed joint favorable substitute language when you vote H.B. No. 6388 out of the committee.

Finally, I would like to express my thanks to the members of the Public Health Committee who, over the years, have supported our department's efforts to change the way persons with intellectual disability are referred to both in statute and in everyday life. Although it seems to

have been done in a piecemeal fashion over several sessions and in several bills, it only has been since 2007 when the department changed its name that the Department of Developmental Services and we set a goal to end the use of all terms that were demeaning and disrespectful to the individuals we support. In just three short years from its first use in 2010 in Governor Rell's Executive Order No. 42, "persons with intellectual disability" has become the respectful and appropriate term throughout Connecticut statute in no small part because of the Public Health Committee's efforts.

In addition to our agency bills, I would like to offer thoughts and comments on several other bills before your committee today. Separate testimony for each of these bills has been submitted.

Thank you again for your continued support of DDS, persons with intellectual disability and individuals with autism spectrum disorder in Connecticut. My staff and I would be happy to answer any questions that you have on House Bill 6388 or any other bills that we have testified on today.

DDS Proposed Joint Favorable Substitute Language for H.B. No. 6388

Section 18. Section 14-96p of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 14-96p. Color of lights. Flashing or revolving lights. Authorized use of blue or green lights. (a)(1) No person shall display upon any motor vehicle any light visible from the front thereof other than white, yellow or amber, or any light other than red, yellow, amber or white visible from the rear thereof, except a light used with any school bus, without a special permit from the commissioner, in accordance with the provisions of subsection (c) of section 14-96q. Notwithstanding this subsection, no permit shall be required for motor vehicles that are (A) equipped with lights in accordance with this section and section 14-96q, (B) owned or leased by the federal government, the state of Connecticut or a Connecticut municipality, (C) registered to such governmental entity, and (D) displaying government plates.

(2) Any vehicle accommodating fifteen or fewer [handicapped] students with disabilities may use a flashing red light or lights during the time such vehicle is stopped for the purpose of receiving or discharging such [handicapped students,] students with disabilities, any motor bus may carry a purple light or lights, any interstate public service vehicle may carry a green light or lights, any taxicab may carry a lunar white light or lights, and any interstate commercial motor vehicle may display green identification lights, in front thereof, as the commissioner may permit.

(3) A vehicle being operated by the chief executive officer of an emergency medical service organization, as defined in section 19a-175, the first or second deputies, or if there are no deputies, the first or second assistants, of such an organization that is a municipal or volunteer or licensed organization, an ambulance, as defined in section 19a-175, a vehicle being operated by a local fire marshal or a local director of emergency management may use a flashing red light or lights or flashing white head lamps and a flashing amber light while on the way to the scene of an emergency, except that an ambulance may use flashing lights of other colors specified by federal requirements for the manufacture of such vehicle. The chief executive officer of each such organization shall provide annually during the month of January, on forms provided by the commissioner, such officer's name and address and the registration number on the number plate or plates of the vehicle on which the authorized red light is or white head lamps and amber light are to be used. A vehicle being operated by a member of a volunteer fire department or company or a volunteer emergency medical technician may use flashing white head lamps, provided such member or emergency medical technician is on the way to the scene of a fire or medical emergency and has received written authorization from the chief law enforcement officer of the municipality to use such head lamps. Such head lamps shall only be used within the municipality granting such authorization or from a personal residence or place of employment, if located in an adjoining municipality. Such authorization may be revoked for use of such head lamps in violation of this subdivision.

(4) Flashing or revolving white lights may not be displayed upon a motor vehicle except (A) on fire emergency apparatus, (B) on motor vehicles of paid fire chiefs and their deputies and assistants, up to a total of five individuals per department, and may be displayed in combination with flashing or revolving red lights, (C) on motor vehicles of volunteer fire chiefs and their deputies and assistants, up to a total of five individuals per department, and may be displayed in combination with flashing or revolving red lights, (D) as a means of indicating a right or left turn, (E) in conjunction with flashing red lights on an ambulance responding to an emergency call, or (F) on the top rear of any school bus. For the purpose of this subsection, the term ["handicapped students" means mentally retarded, hard of hearing, deaf, speech-impaired, visually handicapped, emotionally disturbed, orthopedically impaired or other health-impaired students, or students with specific learning disabilities,] "students with disabilities" means students who have intellectual disability, autism

spectrum disorder, mental disability, visual impairment, blindness, hearing impairment, deafness, speech impairment, orthopedic impairment, or other health-impairments, who by reason thereof, require special education and related services; and the term "flashing white lights" shall not include the simultaneous flashing of head lamps.

(b) A blue light may not be illuminated upon a motor vehicle, except that a vehicle being operated by an active member of a volunteer fire department or company or an active member of an organized civil preparedness auxiliary fire company who has been authorized in writing by the chief executive officer of such department or company may use such a light, including a flashing blue light, while on the way to the scene of a fire or other emergency requiring his services. Such authorization may be revoked by such officer or his successor. The chief executive officer of each volunteer fire department or company or organized civil preparedness auxiliary fire company shall certify annually during the month of January, on forms provided by the commissioner, the names and addresses of members whom he has authorized to use a blue light as provided in this subsection. Such listing shall also designate the registration number on the number plate or plates of the vehicle on which the authorized blue light is to be used.

(c) A flashing green light may not be used upon a motor vehicle, except that a vehicle being operated by an active member of a volunteer ambulance association or company who has been authorized in writing by the chief executive officer of such association or company may use such a light while on the way to the scene of an emergency requiring his services. Such authorization may be revoked by such officer or his successor. The chief executive officer of each volunteer ambulance association or company shall certify annually during the month of January, on forms provided by the commissioner, the names and addresses of members whom he has authorized to use a green light as provided in this subsection. Such listing shall also designate the registration number on the number plate or plates of the vehicle on which the authorized green light is to be used.

(d) Use of lights except as authorized by this section shall be an infraction.

Section 19. Section 17a-75 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17a-75. (Formerly Sec. 17-205b). Definitions. For the purposes of sections 17a-75 to 17a-83, inclusive, the following terms shall have the following meanings: "Business day" means Monday through Friday except when a legal holiday falls thereon; "child" means any person less than sixteen years of age; "court" means the Superior Court-Juvenile Matters or the Court of Probate, unless either court is specifically stated; "hospital for mental illness of children" means any hospital, which provides, in whole or in part, diagnostic or treatment services for mental disorders of children, but shall not include any correctional institution of this state; "mental disorder" means a mental or emotional condition which has substantial adverse effects on a child's ability to function so as to jeopardize his or her health, safety or welfare or that of others, and specifically excludes [mental retardation;] intellectual disability; "parent" means parent or legal guardian, including any guardian appointed under the provisions of subsection (i) of section 46b-129 or sections 45a-132, 45a-593 to 45a-597, inclusive, 45a-603 to 45a-622, inclusive, 45a-629 to 45a-638, inclusive, 45a-707 to 45a-709, inclusive, 45a-715 to 45a-718, inclusive, 45a-724 to 45a-737, inclusive, or 45a-743 to 45a-756, inclusive.

Section 20. Section 17a-451d of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17a-451d. Nonlapsing fund for site acquisition, capital development and infrastructure costs to provide services to persons with mental retardation or psychiatric disabilities. There is established a nonlapsing fund that shall contain (1) any moneys received by the state from the sale, lease or transfer of all or any part of Norwich Hospital or any regional center that takes place after January 1, 2001, and (2) any other moneys required by law to be deposited in a separate account within the General Fund for purposes of this section, section 17a-212a or section 4 of public act 01-154*. The Treasurer shall credit the fund with its investment earnings. Any balance remaining in said fund at the end of any fiscal year shall be carried forward in the fund for the fiscal year next succeeding. The principal and interest of the fund shall be used solely for the purpose of site acquisition, capital development and infrastructure costs necessary to provide services to persons with [mental retardation] intellectual disability or psychiatric disabilities, provided amounts in the fund may be expended only pursuant to appropriation by the General Assembly.

Section 21. Section 17b-28a of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-28a. Waiver Application Development Council. Medicaid waiver unit. (a) There is established a Waiver Application Development Council that shall be composed of the following members: The chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or their designees; the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to human services, or their designees; the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or their designees; the Commissioner of Social Services, or his designee; the Commissioner of Public Health, or his designee; the Commissioner of Mental Health and Addiction Services, or his designee; the Commissioner of Developmental Services, or his designee; the Secretary of the Office of Policy and Management, or his designee; the State Comptroller, or his designee; a representative of advocacy for [mental retardation] persons with intellectual disability to be appointed by the president pro tempore of the Senate; a representative of advocacy for the elderly to be appointed by the majority leader of the Senate; a representative of the nursing home industry to be appointed by the minority leader of the Senate; a representative of the home health care industry, independent of the nursing home industry, to be appointed by the speaker of the House of Representatives; a representative of the mental health profession to be appointed by the majority leader of the House of Representatives; a representative of the substance abuse profession to be appointed by the minority leader of the House of Representatives; a health care provider to be appointed by the president pro tempore of the Senate; two elderly consumers of Medicaid services who are also eligible for Medicare, to be appointed by the speaker of the House of Representatives; a representative of the managed care industry, to be appointed by the president pro tempore of the Senate; a social services care provider, to be appointed by the majority leader of the House of Representatives; a family support care provider, to be appointed by the majority leader of the Senate; two persons with disabilities who are consumers of Medicaid services, one to be appointed by the president pro tempore of the Senate and one to be appointed by the minority leader of the House of Representatives; a representative of legal advocacy for Medicaid clients, to be appointed by the minority leader of the Senate; and six members of the General Assembly, one member appointed by the president pro tempore of the Senate; one member appointed by the majority leader of the Senate; one member appointed by the minority leader of the Senate; one member appointed by the speaker of the House of Representatives; one member appointed by the majority leader of the House of Representatives; and one member appointed by the minority leader of the House of Representatives. The council shall be responsible for advising the Department of Social Services, which shall be the lead agency in the development of a Medicaid Research and Demonstration Waiver under Section 1115 of the Social Security Act for application to the Office of State Health Reform of the United States Department of Health and Human Services by May 1, 1996. The council shall advise the department with respect to specific provisions within the waiver application, including but not limited to, the identification of populations to be included in a managed care program, a timetable for inclusion of distinct populations, expansion of access to care, quality assurance and grievance procedures for consumers and providers. The council shall also advise the department with respect to the goals of the waiver, including but not limited to, the expansion of access and coverage, making state health spending more efficient and to the reduction of uncompensated care.

(b) There is established a Medicaid waiver unit within the Department of Social Services for the purposes of developing the waiver under subsection (a) of this section. The Medicaid waiver unit's responsibilities shall include but not be limited to the following: (1) Administrating the Medicaid managed care program, established pursuant to section 17b-28; (2) contracting with and evaluating prepaid health plans providing Medicaid services, including negotiation and establishment of capitated rates; (3) assessing quality assurance information compiled by the federally required independent quality assurance contractor; (4) monitoring contractual compliance; (5) evaluating enrollment broker performance; (6) providing assistance to the Insurance Department for the regulation of Medicaid managed care health plans; and (7) developing a system to compare performance levels among prepaid health plans providing Medicaid services.

Section 22. Section 17b-112c of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-112c. Alien eligibility for temporary family assistance or state-administered general assistance. (a) Qualified aliens, as defined in Section 431 of Public Law 104-193, who do not qualify for federally-funded cash assistance, other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for solely state-funded temporary family assistance or cash assistance under the state-administered general assistance program, provided other conditions of eligibility are met. An individual who is granted assistance under this section must pursue citizenship to the maximum extent allowed by law as a condition of eligibility unless incapable of doing so due to a medical problem, language barrier or other reason as determined by the Commissioner of Social Services. Notwithstanding the provisions of this section, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance under this section.

(b) Notwithstanding the provisions of subsection (a) of this section: (1) A qualified alien admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for temporary family assistance or cash assistance under the state-administered general assistance program prior to July 1, 1997, or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law, shall remain eligible, and (2) a qualified alien, other lawfully residing immigrant alien admitted into the United States on or after August 22, 1996, other lawfully residing immigrant alien or an alien who formerly held the status of permanently residing under color of law and not determined eligible prior to July 1, 1997, shall be eligible for such assistance subsequent to six months from establishing residency in this state.

(c) Notwithstanding the provisions of this section, a qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance under this section.

Section 23. Section 17b-112c of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-260b. Home and community-based service waivers serving persons with acquired brain injury and persons with mental retardation. Amendments. The Commissioner of Social Services may amend the federal home and community-based service waivers serving persons with acquired brain injury and persons with [mental retardation] intellectual disability to enable such persons eligible for or receiving medical assistance under section 17b-597 to receive the services provided under such federally-approved waivers.

Section 24. Section 17b-342 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-342. (Formerly Sec. 17-314b). Connecticut home-care program for the elderly. (a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the

institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has [mental retardation] intellectual disability shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive process and shall contract with an access agency, approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection (e) of this section, that submits proposals which meet or exceed the minimum bid requirements. In addition to such contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program.

Long-term care facilities shall supply the Department of Social Services with the names and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.

(f) The commissioner may require long-term care facilities to inform applicants for admission of the program established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

(g) The commissioner shall report annually, by June first, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the program in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated savings, and (6) a comparison between costs under the different contracts.

(h) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.

(i) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal poverty level and who is ineligible for Medicaid shall contribute seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per

cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

(j) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

(k) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

Section 25. Section 17b-360 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-360. (Formerly Sec. 17-134y). Nursing facility: Preadmission screening process in the case of persons with mental retardation or condition related thereto. Appeal. (a) For purposes of this section, the terms ["mental retardation"] "intellectual disability, "a condition related to [mental retardation"] intellectual disability" and "specialized services" shall be as defined in Subsection (e)(7)(G)(ii) of Section 1919 of the Social Security Act and federal regulations.

(b) No nursing facility may admit any new resident irrespective of source of payment, who has [mental retardation] intellectual disability or has a condition related to [mental retardation] intellectual disability unless the Department of Developmental Services has determined prior to admission based upon an independent physical and mental evaluation performed by or under the auspices of the Department of Social Services that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility. If the individual requires such level of services, the Department of Developmental Services shall also determine whether the individual requires specialized services for such condition. An individual who is determined by the Department of Developmental Services to have [mental retardation] intellectual disability or to have a related condition and is determined not to require nursing facility level of services shall not be admitted to a nursing facility. In order to implement the preadmission review requirements of this section, and to identify applicants for admission who may have [mental retardation] intellectual disability or have conditions related to [mental retardation] intellectual disability and subject to the requirements of this section, nursing facilities may not admit any individual irrespective of source of payment, unless an identification screen developed, or in the case of out-of-state residents approved, by the Department of Social Services has been completed for the applicant and filed in accordance with federal law.

(c) No payment from any source shall be due to a nursing facility that admits a resident in violation of the preadmission screening requirements of this section.

(d) A nursing facility shall notify the Department of Developmental Services when a resident who has [mental retardation] intellectual disability undergoes a change in condition or when a resident who has not previously been diagnosed as having [mental retardation] intellectual disability undergoes a significant change in condition which may require

specialized services. Upon such notification, the Department of Developmental Services, under the auspices of the Department of Social Services, shall perform an evaluation to determine whether the resident requires the level of services provided by a nursing facility or requires specialized services for [mental retardation.] intellectual disability.

(e) In the case of a resident who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility but to require specialized services for [mental retardation] intellectual disability or a condition related to [mental retardation] intellectual disability and who has continually resided in a nursing facility for at least thirty months before the date of the determination, the resident may elect to remain in the facility or to receive services covered by Medicaid in an alternative appropriate institutional or noninstitutional setting in accordance with the terms of the alternative disposition plan submitted by the Department of Social Services and approved by the Secretary of the United States Department of Health and Human Services.

(f) In the case of a resident with [mental retardation] intellectual disability or a related condition who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility but to require specialized services for [mental retardation] intellectual disability or a related condition and who has not continuously resided in a nursing facility for at least thirty months before the date of the determination, the nursing facility, in consultation with the Department of Developmental Services, shall arrange for the safe and orderly discharge of the resident from the facility. If the department determines that the provision of specialized services requires an alternative residential placement, the discharge and transfer of the patient shall be in accordance with the alternative disposition plan submitted by the Department of Social Services and approved by the Secretary of the United States Department of Health and Human Services, except if an alternative residential facility is not available, the resident shall not be transferred.

(g) In the case of a resident who is determined under subsection (d) of this section not to require the level of services provided by a nursing facility and not to require specialized services, the nursing facility shall arrange for the safe and orderly discharge of the resident from the facility.

(h) The Department of Developmental Services shall be the agency responsible for making the determinations required by this section on behalf of individuals who have [mental retardation] intellectual disability and on behalf of individuals with conditions related to [mental retardation] intellectual disability and may provide services to such individuals to the extent required by federal law.

(i) Any person seeking admittance to a nursing facility or any resident of a nursing facility who is adversely affected by a determination of the Department of Developmental Services under this section may appeal such determination to the Department of Social Services within fifteen days of the receipt of the notice of a determination by the Department of Developmental Services. If an appeal is taken to the Department of Social Services, the determination of the Department of Developmental Services shall be stayed pending determination by the Department of Social Services.

Section 26. Section 17b-616 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 17b-616. (Formerly Sec. 17-582). Family support grant program. (a) As used in this section:

(1) "Child with a disability" means any child who is developmentally disabled as defined in 42 USC 6001(7), except a child with [mental retardation.] intellectual disability.

(2) "Family applicant" means any parent or other family member who resides in the same household as a child with a disability and who has primary responsibility for providing continuous care to the child.

(3) "Family support" means the monthly payment given to a family applicant pursuant to this section and the regulations adopted by the Commissioner of Social Services for the family support grant program.

(b) There is established within the Department of Social Services a family support grant program for the express purpose of providing family support to a family applicant, as defined in subsection (a) of this section.

(c) The Commissioner of Social Services shall adopt regulations, in accordance with the provisions of chapter 54, necessary to establish and implement the family support grant program and to authorize the payment of family support to the family applicant eligible under the terms of this program. The regulations shall include but not be limited to the following areas: (1) The establishment of eligibility criteria for the qualification of the family applicant for family support under this section; (2) the establishment of eligibility criteria for the qualification of a child with a disability; (3) the establishment of a periodic review of the appropriate use of family support to be conducted semiannually by the department.

(d) A family applicant of a child with a disability found eligible by the Commissioner of Social Services pursuant to this section and the regulations adopted thereunder, shall be eligible to receive family support in an amount to be determined by the commissioner.

Section 27. Section 19a-6h of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-6h. State-wide Primary Care Access Authority. Members. Duties. Consultants and assistants. Report. (a) There is established a State-wide Primary Care Access Authority. The authority shall consist of the Commissioners of Public Health and Social Services, the Comptroller, the chairpersons of the HealthFirst Connecticut Authority established under section 19a-6g and the following members: One each appointed by the Connecticut Primary Care Association, the Connecticut State Medical Society, the Connecticut Chapter of the American Academy of Pediatrics, the Connecticut Nurses Association, the Connecticut Association of School-Based Health Centers, the Connecticut State Dental Association, the Connecticut Community Providers Association and the Weitzman Center for Innovation In Community Health and Primary Care. Members shall serve for a term of four years commencing on August 1, 2007. All initial appointments to the committee shall be made by July 15, 2007. Any vacancy shall be filled by the appointing authority.

(b) The chairpersons of the HealthFirst Connecticut Authority established under section 19a-6g shall serve as cochairpersons of the State-wide Primary Care Access Authority. Members shall serve without compensation but shall, within available appropriations, be reimbursed for expenses necessarily incurred in the performance of their duties.

(c) The chairpersons shall convene the first meeting of the State-wide Primary Care Access Authority not later than October 1, 2007. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the committee.

(d) All members appointed to the authority shall be familiar with the criteria of the Institute of Medicine of the National Academies Principles for Healthcare Reform and shall be committed to making recommendations about health care reform for the state of Connecticut that are consistent with said criteria.

(e) The State-wide Primary Care Access Authority shall:

(1) Determine what constitutes primary care services for purposes of subdivisions (2) to (4), inclusive, of this section;

(2) Inventory the state's existing primary care infrastructure, including, but not limited to, (A) the number of primary care providers practicing in the state, (B) the total amount of money expended on public and private primary care services during the last fiscal year, (C) the number of public and private buildings or offices used primarily for the rendering of primary care services, including, but not limited to, hospitals, mental health facilities, dental offices, school-based health clinics, community-based health centers and academic health centers. For the purposes of this subdivision, "primary care provider" means any physician, dentist, nurse, provider of services for [the mentally ill] <u>persons with psychiatric</u>

disabilities or persons with [mental retardation,] intellectual disability, or other person involved in providing primary medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan.

(3) Not later than December 31, 2008, develop a universal system for providing primary care services, including prescription drugs, to all residents of the state that maximizes federal financial participation in Medicaid and Medicare. The committee shall (A) estimate the cost of fully implementing such universal system, (B) identify any additional infrastructure or personnel that would be necessary in order to fully implement such universal system, (C) determine the state's role and the role of third party entities in administering such universal system, (D) identify funding sources for such universal system, and (E) determine the role of private health insurance in such universal system.

(4) Develop a plan for implementing by July 1, 2010, the universal primary care system developed pursuant to subdivision (3) of this section. Such plan shall (A) include a timetable for implementation of the universal primary care system, (B) establish benchmarks to assess the state's progress in implementing the system, and (C) establish mechanisms for assessing the effectiveness of the primary care system, once implemented.

(f) The State-wide Primary Care Access Authority may (1) retain and employ consultants or assistants on a contract or other basis for rendering professional, legal, financial, technical or other assistance or advice as may be required to carry out its duties or responsibilities, and (2) apply for grants or financial assistance from any person, group of persons or corporation or from any agency of the state or of the United States.

(g) On or before February 1, 2008, and annually thereafter on or before January first, the State-wide Primary Care Access Authority shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, insurance and human services, in accordance with the provisions of section 11-4a, concerning its progress in developing the universal primary care services system and the implementation plan for such system.

Section 28. Section 19a-581 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 19a-581. Definitions. As used in this chapter except where the context otherwise requires:

(1) "Department" means the Department of Public Health;

(2) "Commissioner" means the Commissioner of Public Health;

(3) "AIDS" means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;

(4) "HIV infection" means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS;

(5) "HIV-related illness" means any illness that may result from or may be associated with HIV infection;

(6) "HIV-related test" means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection;

(7) "Protected individual" means a person who has been counseled regarding HIV infection, is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness;

(8) "Confidential HIV-related information" means any information pertaining to the protected individual or obtained pursuant to a release of confidential HIV-related information, concerning whether a person has been

counseled regarding HIV infection, has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual's partners;

(9) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this subdivision;

(10) "Partner" means an identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual;

(11) "Health facility" means an institution, as defined in section 19a-490, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory or facility providing care or treatment to [the mentally ill] persons with psychiatric disabilities or persons with [mental retardation] intellectual disability or a facility for the treatment of substance abuse;

(12) "Health care provider" means any physician, dentist, nurse, provider of services for [the mentally ill] persons with psychiatric disabilities or persons with [mental retardation,] intellectual disability, or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

(13) "Significant risk of transmission" means sexual activity that involves the transfer of one person's semen, vaginal or cervical secretions to another person or sharing of needles during intravenous drug use. The department may further define significant risk of transmission in regulations adopted pursuant to section 19a-589;

(14) "Significant exposure" means a parenteral exposure such as a needlestick or cut, or mucous membrane exposure such as a splash to the eye or mouth, to blood or a cutaneous exposure involving large amounts of blood or prolonged contact with blood, especially when the exposed skin is chapped, abraded, or afflicted with dermatitis. The department may further define significant exposure in regulations adopted pursuant to section 19a-589;

(15) "Exposure evaluation group" means at least three impartial health care providers, at least one of whom shall be a physician, designated by the chief administrator of a health facility, correctional facility or other institution to determine if a health care or other worker has been involved in a significant exposure. No member of the group shall be directly involved in the exposure. The department may further define exposure evaluation group in regulations adopted pursuant to section 19a-589.

Section 29. Section 26-29a of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 26-29a. Free lifetime fishing licenses for persons with mental retardation. No fee shall be charged for any sport fishing license issued under this chapter to any person with [mental retardation,] intellectual disability, and such license shall be a lifetime license not subject to the expiration provisions of section 26-35. Proof of [mental retardation] intellectual disability shall consist of a certificate to that effect issued by any person licensed to practice medicine and surgery in this state.

Section 30. Section 27-103 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 27-103. Definitions. (a) As used in the general statutes, except chapter 504, and except as otherwise provided: (1) "Armed forces" means the United States Army, Navy, Marine Corps, Coast Guard and Air Force and any reserve component thereof, including the Connecticut National Guard performing duty as provided in Title 32 of the United States Code; (2) "veteran" means any person honorably discharged from, or released under honorable conditions from active service in, the armed forces; (3) "service in time of war" means service of ninety or more cumulative days except, if the period of war lasted less than ninety days, "service in time of war" means service for the entire period of war, unless separated from service earlier because of a service-connected disability rated by the Veterans' Administration, during a period of war; and (4) "period of war" has the same meaning as provided in 38 USC 101, as amended, except that the "Vietnam Era" means the period beginning on February 28, 1961, and ending on July 1, 1975, in all cases; and "period of war" shall include service while engaged in combat or a combat support role in Lebanon, July 1, 1958, to November 1, 1958, or September 29, 1982, to March 30, 1984; Grenada, October 25, 1983, to December 15, 1983; Operation Earnest Will, involving the escort of Kuwaiti oil tankers flying the United States flag in the Persian Gulf, July 24, 1987, to August 1, 1990; and Panama, December 20, 1989, to January 31, 1990, and shall include service during such periods with the armed forces of any government associated with the United States.

(b) As used in this part, "home" means the Veterans' Home maintained by the state; "hospital" means any incorporated hospital or tuberculosis sanatorium in the state and any state chronic disease [hospital, mental hospital or training school for the mentally retarded,] hospital or hospital for persons with mental illness, "veteran" means any veteran who served in time of war, as defined in subsection (a) of this section, and who is a resident of this state, provided, if he was not a resident or resident alien of this state at the time of enlistment or induction into the armed forces, he shall have resided continuously in this state for at least two years; "eligible dependent" means any parent, wife or husband, or child of a veteran who has no adequate means of support; and "eligible family member" means any parent, brother or sister, wife or husband, or child or children under eighteen years of age, of any veteran whose cooperation in the program is integral to the treatment of the veteran.

Section 31. Section 31-57e of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 31-57e. Contracts between the state and federally recognized Indian tribes. Employment Rights Code; protection of persons employed by a tribe. (a) As used in this section:

(1) "Commercial enterprise" means any form of commercial conduct or a particular commercial transaction or act, including the operation of a casino, which relates to or is connected with any profit-making pursuit;

(2) "Labor organization" means any organization which exists for the purpose, in whole or in part, of collective bargaining or of dealing with employers concerning grievances, terms or conditions of employment, or of other mutual aid or protection in connection with employment;

(3) "Tribe" means any federally recognized Indian tribe which is subject to the Indian Gaming Regulatory Act, P.L. 100-497, 25 USC 2701 et seq.

(b) The state shall not provide any funds or services which directly or indirectly assist any tribe engaged in a commercial enterprise until the tribe adopts an Employment Rights Code established pursuant to subsection (e) of this section, unless such funds or services are (1) required by federal or state law, (2) were agreed to in writing prior to July 1, 1993, or (3) are provided to a project which is covered by federal or state employment regulations or employment rights laws. This subsection shall not be construed to prohibit the state from enforcing any civil or criminal law, or any gaming regulation at a commercial enterprise owned or operated by a tribe, or to require the state to enforce a violation of any criminal law which would not be a violation if it occurred outside tribal land. The Governor, upon consulting with the leaders of the General Assembly, may waive the restrictions set forth in this subsection in the event of a declared emergency.

(c) The state shall oppose any application by a tribe, pursuant to 25 CFR chapter 151, to convert any parcel of fee interest land to federal trust status. The conversion shall be deemed contrary to the interest of the state and its residents.

(d) The Governor shall include in each future proposal by the state in negotiations conducted pursuant to the Indian Gaming Regulatory Act, a provision requiring the adoption of an Employment Rights Code established pursuant to subsection (e) of this section. The Governor shall employ his best efforts to ensure that any final agreement, compact or contract established under the Indian Gaming Regulatory Act includes an Employment Rights Code in accordance with subsection (e) of this section.

(e) The Employment Rights Code referred to under this section shall include the following provisions:

(1) A commercial enterprise subject to tribal jurisdiction shall not, except in the case of a bona fide occupational qualification or need, refuse to hire or employ or bar or discharge from employment any individual or discriminate against him in compensation or in terms, conditions or privileges of employment because of the individual's race, color, religious creed, sex, gender identity or expression, marital status, national origin, ancestry, age, present or past history of mental disorder, [mental retardation,] intellectual disability, sexual orientation, learning or physical disability, political activity, union activity or the exercise of rights protected by the United States Constitution. This subdivision shall not be construed to restrict the right of a tribe to give preference in hiring to members of the tribe.

(2) A commercial enterprise subject to tribal jurisdiction shall not deny any individual, including a representative of a labor organization, seeking to ensure compliance with this section, access to employees of the tribe's commercial enterprise during nonwork time in nonwork areas. The tribe shall not permit any supervisor, manager or other agent of the tribe to restrict or otherwise interfere with such access.

(3) When a labor organization claims that it has been designated or selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes, the labor organization may apply to an arbitrator to verify the claim pursuant to subdivision (4) of this subsection. If the arbitrator verifies that the labor organization has been designated or selected as the bargaining representative by a majority of the employees in an appropriate unit, the tribe shall, upon request, recognize the labor organization as the exclusive bargaining agent and bargain in good faith with the labor organization in an effort to reach a collective bargaining agreement. However, the arbitrator shall disallow any claim by a labor organization which is dominated or controlled by the tribe.

(4) (A) Any individual or organization claiming to be injured by a violation of any provision of this subsection shall have the right to seek binding arbitration under the rules of the American Arbitration Association. Such

individual or organization shall file a demand for arbitration with the tribe not later than one hundred eighty days after the employee or labor organization knows or should know of the tribe's violation of any provision of this subsection. The demand shall state, in plain language, the facts giving rise to the demand.

(B) The demand for arbitration shall also be served upon the Connecticut office of the American Arbitration Association. Absent settlement, a hearing shall be held in accordance with the rules and procedures of the American Arbitration Association. The costs and fees of the arbitrator shall be shared equally by the tribe and the labor organization.

(C) The decision of the arbitrator shall be final and binding on both parties and shall be subject to judicial review and enforcement against all parties in the manner prescribed by chapter 909.

(5) A tribe shall not retaliate against any individual who exercises any right under the Employment Rights Code. Any individual or organization claiming to be injured by a violation of the provisions of this section shall have the right to seek binding arbitration pursuant to subdivision (4) of this subsection.

(f) Notwithstanding the provisions of this section, the Governor may negotiate an agreement with a tribe which establishes rights for employees of commercial enterprises subject to tribal jurisdiction in addition to those provided under the Employment Rights Code established under subsection (e) of this section.

Section 32. Section 32-204 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 32-204. Purposes and powers of the authority. The general purpose of the authority shall be to stimulate new spending in Connecticut and to encourage the diversification of the state economy through the construction, operation, maintenance and marketing of a conference or exhibition facility that will create new jobs, add to the benefits of the hospitality industry, broaden the base of the tourism effort and stimulate substantial surrounding economic development and corresponding increased tax revenues to the state. The primary purpose of the authority shall be to attract and service large conventions, tradeshows, exhibitions and conferences, preferably those whose attendees are predominantly from out-of-state; the secondary purpose of the authority, at times when its primary purpose cannot be fulfilled, shall be to attract and service local consumer shows, exhibitions and events which generate less new spending in Connecticut. For these purposes, the authority shall have the following powers: (1) To have perpetual succession as a body corporate and to adopt procedures for the regulation of its affairs and the conduct of its business as provided in subsection (f) of section 32-203; to adopt a corporate seal and alter the same at its pleasure; and to maintain an office at such place or places within the state as it may designate; (2) to sue and be sued; to contract and be contracted with, provided, if management, operating, or promotional contracts or agreements or other contracts or agreements are entered into with nongovernmental parties with respect to property financed with the proceeds of obligations the interest on which is excluded from gross income for federal income taxation, the board of directors will ensure that such contracts or agreements are in compliance with the covenants of the authority upon which such tax exclusion is conditioned; (3) to acquire, by gift, purchase, condemnation or transfer, lands or rights-in-land in connection therewith and to sell, lease as lessee or as lessor, provided such activity is consistent with all applicable federal tax covenants of the authority, transfer or dispose of any property or interest therein acquired by it, at any time; and to receive and accept aid or contributions, from any source, of money, labor, property or other things of value, to be held, used and applied to carry out the purposes of sections 32-200 to 32-212, inclusive, subject to the conditions upon which such grants and contributions are made, including, but not

limited to, gifts or grants from any department, agency or instrumentality of the United States or this state for any purpose consistent with said sections; (4) to formulate plans for, acquire, finance and develop, lease, purchase, construct, reconstruct, repair, improve, expand, extend, operate, maintain and market the project, provided such activities are consistent with all applicable federal tax covenants of the authority; (5) to fix and revise from time to time and to charge and collect fees, rents and other charges for the use, occupancy or operation of the project, and to establish and revise from time to time, regulations in respect of the use, operation and occupancy of any such project, provided such regulations are consistent with all applicable federal tax covenants of the authority; (6) to employ such assistants, agents and other employees as may be necessary or desirable to carry out its purposes and to fix their compensation; to establish and modify personnel procedures as may be necessary from time to time and to negotiate and enter into collective bargaining agreements with labor unions; (7) to engage architects, engineers, attorneys, accountants, consultants and such other independent professionals as may be necessary or desirable to carry out its purposes; to contract for construction, development, concessions and the procurement of goods and services and to establish and modify procurement procedures from time to time to implement the foregoing in accordance with the provisions of subsection (b) of this section; (8) to adopt procedures with respect to contractors and subcontractors engaged in the construction of the project which require such contractors or subcontractors (A) to take affirmative action to provide equal opportunity for employment without discrimination as to race, creed, color, national origin, ancestry, sex, gender identity or expression, marital status, age, lawful source of income, [mental retardation,] intellectual disability, mental disability or physical disability, including, but not limited to, blindness or deafness, and (B) to ensure that the wages paid on an hourly basis to any mechanic, laborer or workman employed by such contractor or subcontractor with respect to the project shall be at a rate equal to the rate customary or prevailing for the same work in the same trade or occupation in the town and city of Stamford; (9) to engage in and contract for marketing and promotional activities to attract national, regional and local conventions, trade shows, exhibitions, banquets and other events in order to maximize the use of the project and to carry out the purposes of sections 32-200 to 32-212, inclusive; (10) to acquire, lease, hold and dispose of personal property for the purposes set forth in sections 32-200 to 32-212, inclusive; (11) to procure insurance against any liability or loss in connection with its property and other assets, in such amounts and from such insurers as it deems desirable and to procure insurance for employees; (12) to borrow money and to issue bonds, notes and other obligations of the authority to the extent permitted under sections 32-200 to 32-212, inclusive, to fund and refund the same and to provide for the rights of the holders thereof and to secure the same by pledge of assets, revenues, notes and state contract assistance as provided in said sections and such state taxes as the authority shall be entitled to receive pursuant to the provisions of said sections; (13) to invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state of Connecticut and in other obligations which are legal investments for savings banks in this state and in time deposits or certificates of deposit or other similar banking arrangements secured in such manner as the authority determines; (14) to do anything necessary and desirable, including executing reimbursement agreements or similar agreements in connection with credit facilities, including, but not limited to, letters of credit or policies of bond insurance, remarketing agreements and agreements for the purpose of moderating interest rate fluctuations, to render any bonds to be issued pursuant to sections 32-200 to 32-212, inclusive, more marketable; (15) to do all acts and things necessary or convenient to carry out the purposes of sections 32-200 to 32-212, inclusive, and the powers expressly granted by said sections.

Section 33. Section 38a-488a of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 38a-488a. Mandatory coverage for the diagnosis and treatment of mental or nervous conditions. Exceptions. Benefits payable re type of provider or facility. State's claim against proceeds. (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2000, shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) [mental retardation,] intellectual disability, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(b) No such policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.

(c) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.

(d) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:

(1) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(2) A social worker who was certified as an independent social worker under the provisions of chapter 383b prior to October 1, 1990;

(3) A licensed marital and family therapist who has completed at least two thousand hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(4) A marital and family therapist who was certified under the provisions of chapter 383a prior to October 1, 1992;

(5) A licensed alcohol and drug counselor, as defined in section 20-74s, or a certified alcohol and drug counselor, as defined in section 20-74s; or

(6) A licensed professional counselor.

(e) For purposes of this section, the term "covered expenses" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "covered expenses" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.

(f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist, or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist, or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (d) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

(i) In the case of any person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services, the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478.

Section 34. Section 38a-514 of the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 38a-514. (Formerly Sec. 38-174d). Mandatory coverage for the diagnosis and treatment of mental or nervous conditions. Exceptions. Benefits payable re type of provider or facility. State's claim against proceeds. (a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2000, shall provide benefits for the diagnosis and treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) [mental retardation,] intellectual disability, (2) learning disorders, (3)

motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

(b) No such group policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions.

(c) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.

(d) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:

(1) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(2) A social worker who was certified as an independent social worker under the provisions of chapter 383b prior to October 1, 1990;

(3) A licensed marital and family therapist who has completed at least two thousand hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

(4) A marital and family therapist who was certified under the provisions of chapter 383a prior to October 1, 1992;

(5) A licensed alcohol and drug counselor, as defined in section 20-74s, or a certified alcohol and drug counselor, as defined in section 20-74s; or

(6) A licensed professional counselor.

(e) For purposes of this section, the term "covered expenses" means the usual, customary and reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "covered expenses" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, and a provider, as defined in section 38a-478.

(f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section.

(g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (d) of this section; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

(h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center.

(i) In the case of any person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478.

(j) A group health insurance policy may exclude the benefits required by this section if such benefits are included in a separate policy issued to the same group by an insurance company, health care center, hospital service corporation, medical service corporation or fraternal benefit society. Such separate policy, which shall include the benefits required by this section and the benefits required by section 38a-533, shall not be required to include any other benefits mandated by this title.

(k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting.

(l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility must be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Section 35. Section 38a-816 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof:

Sec. 38a-816. (Formerly Sec. 38-61). Unfair practices defined. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (b) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (f) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (h) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of, any oral or written statement or any pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive; or making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (b) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (d) refusing to pay claims without conducting a reasonable investigation based upon all available information; (e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (h) attempting to settle a claim for less than the amount to which a reasonable man would have believed he

was entitled by reference to written or printed advertising material accompanying or made part of an application; (i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (j) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (l) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; (n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; (o) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

(7) Failure to maintain complaint handling procedures. Failure of any person to maintain complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subsection "complaint" shall mean any written communication primarily expressing a grievance.

(8) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money or other benefit from any insurer, producer or individual.

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: (a) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (b) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (c) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year.

(10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so licensed.

(11) Favored agent or insurer: Coercion of debtors. (a) No person may (i) require, as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or group of producers; (ii) unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien; (iii) require directly or indirectly that any borrower, mortgagor, purchaser, insurer or producer pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another; or (iv) use or disclose information resulting from a requirement that a borrower, mortgagor

or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer or the producer complying with such a requirement. (b)(i) Subsection (a)(iii) does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subsection (a)(ii), such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subsection applies to determine whether such person has violated this subsection. If a violation of this subsection is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

(12) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of physical disability, mental or nervous condition as set forth in section 38a-488a or [mental retardation,] intellectual disability, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(13) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. For purposes of this subdivision, "refusal to insure" includes the denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured is blind or partially blind, except that an insurer may exclude from coverage any disability, consisting solely of blindness or partial blindness, when such condition existed at the time the policy was issued. Any individual who is blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons with respect to all other conditions, including the underlying cause of the blindness or partial blindness.

(14) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of exposure to diethylstilbestrol through the female parent.

(15) (A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers, within the time periods set forth in subparagraph (B) of this subdivision, unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, who fails to pay such a claim or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center.

(B) Each insurer or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than:

(i) For claims filed in paper format, sixty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested; and

(ii) For claims filed in electronic format, twenty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) notify the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than ten days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than ten days after the insurer receives the information requested.

(C) As used in this subdivision, "health care provider" means a person licensed to provide health care services under chapter 368d, chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

(16) Failure to pay, as part of any claim for a damaged motor vehicle under any automobile insurance policy where the vehicle has been declared to be a constructive total loss, an amount equal to the sum of (A) the settlement amount on such vehicle plus, whenever the insurer takes title to such vehicle, (B) an amount determined by multiplying such settlement amount by a percentage equivalent to the current sales tax rate established in section 12-408. For purposes of this subdivision, "constructive total loss" means the cost to repair or salvage damaged property, or the cost to both repair and salvage such property, equals or exceeds the total value of the property at the time of the loss.

(17) Any violation of section 42-260, by an extended warranty provider subject to the provisions of said section, including, but not limited to: (A) Failure to include all statements required in subsections (c) and (f) of section 42-260 in an issued extended warranty; (B) offering an extended warranty without being (i) insured under an adequate extended warranty reimbursement insurance policy or (ii) able to demonstrate that reserves for claims contained in the provider's financial statements are not in excess of one-half the provider's audited net worth; (C) failure to submit a copy of an issued extended warranty form or a copy of such provider's extended warranty reimbursement policy form to the Insurance Commissioner.

(18) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because such individual has been a victim of family violence.

(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other medical information.

An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited symptoms of such disease or condition. For the purposes of this subsection, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

(20) Any violation of sections 38a-465 to 38a-465q, inclusive.

(21) With respect to a managed care organization, as defined in section 38a-478, failing to establish a confidentiality procedure for medical record information, as required by section 38a-999.

(22) Any violation of sections 38a-591d to 38a-591f, inclusive.